AGENDA

PUBLIC HEALTH ADVISORY BOARD

July 15, 2021, 2:00-4:00 pm

Join ZoomGov Meeting
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Meeting ID: 160 988 9971
Passcode: 134813
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Meeting objectives:

- Welcome and introduce new board members
- Approve June meeting minutes
- Discuss Public Health Advisory Board subcommittees

2:00-2:30 pm	**Welcome, updates and agenda review** • Welcome new members • ACTION: Approve June meeting minutes • PHAB training and retreat • Update on Curry County public health services • Legislative session recap	Veronica Irvin, PHAB Chair
2:30-2:45 pm	**Discuss PHAB subcommittees** • Provide update on subcommittee work ahead • ACTION: Approve subcommittee public health modernization funding recommendations	Bob Dannenhoffer, PHAB Incentives and Funding Subcommittee

2:45-3:50 pm	**Health equity training and planning for a PHAB retreat** • Recap PHAB conversations to date and future plans related to supporting next steps based on recommendations from survey modernization partners • Discuss PHAB training opportunities with Health Resources in Action	Mo Barbosa and Brittany Chen, Health Resources in Action Victoria Demchak, OHA PHAB members
3:50-4:00 pm	**Public comment**	Veronica Irvin, PHAB Chair
4:00 pm	**Next meeting agenda items and adjourn**	Veronica Irvin, PHAB Chair

PUBLIC HEALTH ADVISORY BOARD (PHAB) MEETING MINUTES
June 17, 2021, 2:00-4:00 pm

Attendance

Board members present: Dr. Eli Schwarz, Kelle Little, Dr. Bob Dannenhoffer, Dr. Veronica Irvin, Dr. Jeanne Savage, Dr. David Bangsberg, Rebecca Tiel, Sarah Poe, Dr. Sarah Present, Rachael Banks, Carrie Brogoitti, Eva Rippleteau, Jocelyn Warren

Board members absent: Dr. Dean Sidelinger, Alejandro Queral, Erica Sandoval

Oregon Health Authority (OHA) staff: Cara Biddlecom, Lisa Rau, Sara Beaudrault, Victoria Demchak, Steph Jarem, Laura Daily

Members of the public: Sarah Pettey, Jackie Leung, AHO/We Can Do Better

Meeting Objectives

- Welcome and introduction of new board members
- Approve May meeting minutes
- Provide updates on Curry County public health services and legislative session
- Discuss Public Health Advisory Board subcommittees
- Discuss the 1115 Medicaid Waiver application

Welcome and Agenda Review
Veronica Irvin**,** *PHAB Chair*

Cara Biddlecom took role. A quorum was present.

Veronica announced that there were two new PHAB members starting today.

Jocelyn Warren, representing Local Public Health Administrators, has been a Lane County Health Administrator for six years, and is happy to join the PHAB.

Erica Sandoval, representing State Employees, the COVID-19 Equity Director.

The May meeting minutes were presented and approved, with Eva Rippleteau and Jocelyn Warren abstaining.

Update on Curry County Public Health Services
Cara Biddlecom, *OHA*

The Curry County Board of Commissioners resolved in April to transfer public health authority to OHA. The official date of transition will be July 1, 2021. There will be a town hall meeting on June 22 for Curry County residents. OHA is working closely with the county and our internal teams to make this transition successful. Josephine County is helping to provide some health services as well.

Update on Legislative Session
Cara Biddlecom, *OHA*

Cara shared that the legislative session is ending in the next few days, so she will be able to give a more updated report next month.

In this session, there was an additional $45 million investment made towards Public Health Modernization for the 2021-23 fiscal budget. This is on top of the $15.6 million that had already been awarded, bringing the total to over $60 million towards Public Health Modernization. We will be coming back to the PHAB committee to make sure we are on track with the framework and priorities that were set 1 ½ years ago for these funds. It will be important to make sure we stay on course with your suggestions.

A question was asked about a federal bill that was presented in March called "Public Health Saves Lives." Does anyone know if this funding will be happening? Cara shared that we have received federal money from the American Rescue Plan Act. Oregon has been awarded $25.67 million starting July 1, mostly to fund school-based health personnel, OHA staff, and local public health workers.

Another question was asked if the counties who have turned over their public health authority to OHA get access to some of this money. The answer is not directly, but OHA use the counties' share of federal money toward supporting those counties.

Discussion of PHAB Subcommittees

- Veronica introduced the PHAB Incentive and Funding subcommittee and encouraged PHAB members to join. The current members are Bob and Carrie. Members can belong to more than one committee.

- Sarah Present provided an update on the PHAB Accountability Metrics subcommittee. They had a productive breakfast meeting. Follow-up information was provided on Public Health Modernization that was presented at the last PHAB meeting. How can we look at metrics in a way that is actionable and moves Public Health forward? They discussed what the deliverables and timelines for the committee will be. "When we talk about accountability metrics, we need to know who exactly we are accountable to. "

- Veronica Irvin provided an update on the PHAB Strategic Data Plan subcommittee.

1115 Medicaid Waiver Application and Discussion
Steph Jarem, *OHA*

Steph presented a slideshow providing information on the 1115 Medicaid Waiver. Her goal was to present an overview and history of the waiver along with the steps being taken to draft the policy concept paper. Then she would follow up with outlining the strategies and next steps in the process. The entire slideshow is included in today's meeting packet for anyone who would like additional information about the waiver.

Public Comment Period
There were no public comments. This period was closed.

PHAB Member discussion
Veronica Irvin**,** *PHAB Chair*

Veronica asked the committee what topics they would like to see discussed at future meetings.

- There is not a good system of data-sharing between the federal immunization databases and state data systems. So much of this data is important, and we need to be able to track it.

- Laura has helped created a presentation on how funding levels work in Public Health administration, and what the funds would be going towards at each level. She shared this presentation with legislators and others, and she would be happy to give this presentation to the PHAB.

- Are there any agencies doing an "after-action report" to see what lessons were learned? The suggestion was made that PHAB does not need to lead it but should participate in it. It was added that LPHAs should participate in this process as well.

- Help with National Accreditation for counties in Oregon. This would fit nicely into the Public Health Modernization effort. How can we bring all counties up to standards? Can counties possibly work together on this process?

Next Meeting Agenda Items and Adjourn
Veronica Irvin, *PHAB Chair*

- Report on legislative session
- Reports from the PHAB subcommittees
- Possibly to include items discussed above.

The meeting was dismissed at 3:45 pm.

The next meeting will be held on Thursday, July 15, from 2-4 p.m.

OHA 2021 Legislative End-of-Session Report

Centering Health Equity

The Oregon Health Authority (OHA) seeks to eliminate health inequities in Oregon by 2030. The vision of health equity that OHA and the Oregon Health Policy Board are working to achieve is:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address the equitable distribution or redistribution of resources and power; and recognizing, reconciling and rectifying historical and contemporary injustices.*

The past year has been profoundly challenging due to the COVID-19 pandemic, wildfires, and ice storms. While every person in Oregon has been affected, it is overwhelmingly clear that some individuals and communities – those that had already been economically or socially marginalized, or who had already suffered greater health difficulties – experienced worse health impacts from these events. For example, Pacific Islander, American Indian/Alaska Native, African American and Black, and Latino/Latina/Latinx and Hispanic populations in Oregon each had more than twice the rate of COVID-19 cases per capita as white non-Hispanic populations.

This reality overlapped with the long overdue racial reckoning, sparked by George Floyd's murder and other cases of violence against Black people, as well as attacks upon democracy at both the state capital and national capital.

The Governor convened the first ever Racial Justice Council (RJC) to change how we listen to, engage with, respond to, and support Black, Indigenous and People of Color (BIPOC) and Tribal Communities in Oregon. Many of the health equity investments and initiatives listing in this report reflect RJC priorities. Through them, the legislature provided OHA and its partners new opportunities to center health equity and work to eliminate health inequities. Together, the bills and budget investments discussed below reflect a deeper commitment to health equity by OHA and in the legislature.

As OHA implements these commitments and investments, its work will be guided by collaboration with community partners, especially those individuals and communities most harmed by health inequities stemming from contemporary and historical racism, oppression, discrimination, bigotry and bias.

Overview of an Historic and Transformative Budget

The top-line numbers for OHA's 2021-2023 budget, including the main budget bill plus several standalone bills, are:

- $30.2 billion in total funds, up from $25.6 billion last biennium.
- $3.5 billion in state general funds, up from $2.4 billion.
- 4,763 positions, up from 4,440.

A legislative report describing OHA's budget in more detail can be found here.

HB 5024 – the main budget bill – fully funds OHA's current service levels. That means, for the coming biennium, OHA generally will provide the same services it provided last biennium to Oregonians who need them. In particular, the Oregon Health Plan (OHP) is fully funded with no service cuts, even though membership has increased greatly due to COVID-19. Fully funding OHP is a critical element of working towards eliminating health inequities by 2030.

In addition, the budget makes other major investments in health equity, behavioral health, and public health. Through these investments, the legislatively approved budget for OHA will allow for important transformations in how the agency delivers services, thereby enabling OHA to better serve and meet the needs of Oregonians. (Dollar amounts are from the state general fund unless noted. Also, many of the bills discussed below have their own funding separate from HB 5024.)

Health Equity

- $6.8 million ($5.5 million state general fund, $0.5 million other state funds, $0.9 million federal) to build and sustain health equity infrastructure.
- $400,000 ($288,000 state general fund, $24,000 other state funds, $47,000 federal) to create a Tribal Traditional Health Worker category.
- $15 million ($1.4 million state general fund, $13.5 million federal) to operate Indian Managed Care Entities.

Behavioral Health

- $130 million ($65 million state general fund, $65 million federal) to increase residential treatment, services and housing for people with behavioral health needs.
- $121 million ($24.5 million state general fund, $96.5 million federal) for certified community behavioral health clinics (CCBHCs).
- $50 million for transformation and system alignment in the behavioral health system.
- $31 million to open two, 24-bed patient units at Oregon State Hospital.
- $21.5 million ($19.2 million state general fund, $2.3 million federal) for community services for "Aid & Assist" patients.
- $20 million set aside for Oregon State Hospital staffing.
- $302 million (other funds) for addiction and recovery services called for in Ballot Measure 110, and backfills the $70 million that Ballot Measure 110 had redirected from other critical behavioral health services.

Public Health

- $45 million for public health modernization.
- $7.8 million ($4.6 million state general fund, $3.2 million federal) for universally offered home visiting for newborns.

- $2.2 million for initial implementation of psilocybin services established by Ballot Measure 109.
- $1.2 million to restore funding to the Oregon WIC Program and Oregon Farm Direct Nutrition Program, which serves low-income seniors and WIC families.

Improving Access and Quality of Behavioral Health Services and Decreasing Behavioral Health Inequities

Behavioral health received critical attention in the legislature this year, in several wide-ranging bills. Furthermore, the new OHA budget includes the legislature's largest ever investment focused on behavioral health. Taken together, several initiatives aim to provide needed behavioral health services, while also transforming the entire behavioral health system to one that is simple, responsive, and meaningful for the people it serves. OHA will do this with active involvement of the people and communities who have faced behavioral health challenges and inequities.

1. **Increase Accountability and Quality of Behavioral Health Services** (HB 2086)

Beginning with the recommendations of Governor Brown's Behavioral Health Advisory Council, over the course of the legislative session HB 2086 became an even more comprehensive behavioral health bill. The bill calls for: enhanced support for culturally-specific peer led services, including support for tribal-based practices; integrated treatment for co-occurring disorders (substance addiction and mental health disorders together); reduction of administrative burdens in behavioral health clinical documentation and reporting; an analysis of pay and equity disparities affecting the behavioral health workforce; high quality and rapid access to alcohol and drug treatment as guided by the Alcohol & Drug Policy Commission; specialized housing navigation assistance; expansion and enhancement of the child, family and adolescent behavioral health system specific to access of services at all levels of care that is driven by real-time data; and more. All of these enhancements are intended to be linked to a new accountability program that takes up the Governor's Behavioral Health Advisory Council's system transformation recommendations and creates new requirements, structures and incentives for OHA, payors, and providers to engage with people they serve and work together to make the behavioral health system function better as a whole. The accountability program is designed to apply directly to both payors and providers with stronger oversight by OHA and the Oregon Health Policy Board (OHPB). It provides greater transparency and accountability not only for new investments but also for OHA's existing behavioral health infrastructure. The program is directly linked to OHA's 2021-2023 budget, HB 5024. The metrics and outcomes defined by the HB 2086 process will be integrated into contracts and grants provided by the regional development and innovation fund established in HB 5024. Furthermore, the rules and contracts involved in this effort will be written and negotiated with input from people with lived experience, communities, and providers.

2. **Fund Behavioral Health Housing** (HB 5024-OHA Budget)

OHA's budget includes $130 million ($65 million general fund and $65 million from the federal American Rescue Plan Act) for capital, start-up, and operational costs related to increasing statewide capacity of licensed residential facilities and housing for people with behavioral health needs. A budget note establishes a planning grant process and criteria related to these funds.

3. **Fund Certified Community Behavioral Health Clinics** (HB 5024-OHA Budget)

OHA's budget includes $121 million ($24.5 million state general fund, $96.5 million federal) for certified community behavioral health clinics (CCBHCs). These funds will enable existing CCBHCs to provide services through the 2021-23 biennium. Also, OHA will evaluate the CCBHC model in Oregon and report findings to the legislature.

4. **Strengthen the Crisis Care System** (HB 2417)

HB 2417 aims to build upon and improve Oregon's statewide coordinated crisis system. It outlines the expectations for local mobile crisis intervention teams, crisis stabilization centers, and other behavioral supports. This includes a 9-8-8 phone line (like 9-1-1 but focused on behavioral health) to provide behavioral health crisis intervention services and crisis care coordination anywhere in the state 24 hours per day, seven days per week, 365 days per year.

5. **Support Drug Addiction and Recovery Services** (HB 5024-OHA Budget, SB 755)

In November 2020, Oregon voters approved Ballot Measure 110, which aims to establish a more health-based, equitable, and effective approach to treating substance use disorders by shifting the response to drug possession from criminalization to treatment and recovery. The legislature funded the $302 million for addiction and recovery services called for in the measure, and also backfilled the $70 million that Ballot Measure 110 had redirected from other needed behavioral health services. In addition, SB 755, which was developed cooperatively with advocates of the measure, clarified several aspects of the new law so that it can be implemented more effectively.

6. **Strengthen the Behavioral Health Workforce** (HB 2949)

Oregon needs a behavioral health workforce that is stronger, more diverse, more culturally responsive, and better supported. HB 2949 provides incentives to increase the recruitment, retention, and diversification of the behavioral health workforce in addition to using incentives to increase Oregonians' access to culturally responsive services. The types of incentives specified in the bill include pipeline development, scholarships for undergraduates and stipends for graduate students, loan repayments, and retention activities. It provides $60 million to increase training for diverse behavioral health professionals, both licensed and non-licensed, and $20 million for a grant program to licensed behavioral health professionals to provide supervised clinical experience to associates or other individuals who have the necessary education but need supervised clinical experience to obtain a license to practice. The bill also requires OHA to coordinate with the Higher Education Coordinating Commission in considering investments in the behavioral health workforce.

7. **Promote Peer Respite Services** (HB 2980)

HB 2980 provides $6 million for peer-run organizations in the Portland metropolitan area, southern Oregon region, Oregon coast, and eastern and central Oregon region to operate peer respite centers. These peer respite services aid individuals with behavioral health challenges or trauma response symptoms who experience acute distress, anxiety, or emotional pain that may lead to need for higher level of care. At least one of the peer respite centers must participate in a pilot project designed specifically to provide culturally responsive services to historically underrepresented communities.

8. **Ensure Mental Health Parity** (HB 3046)

HB 3046 aims to ensure that treatment and services for mental health and substance use disorders are provided in a broadly similar manner to comparable physical health services, including provider reimbursement. The bill requires CCOs to provide information to OHA on treatment limitations and denials of behavioral health services, and requires OHA to annually report on CCO compliance with federal parity law, adequacy of provider networks, and coverage of behavioral health services.

9. **Maintain the Prescription Drugs Monitoring Program** (HB 2074)

The Prescription Drug Monitoring Program (PDMP) allows prescribers to be fully informed of the prescription history of their patients when prescribing controlled substances. Since it was created in statute in 2019, the PDMP has expanded substantially in both function and size. Various enhancements brought the PDMP in line with legislative mandates and with emerging best practices, including interstate data sharing, health information technology (HIT) integration, improved user interface, and collection of additional drugs and fields for clinical use and research purposes. However, this growth increased the cost of operation so that it is no longer covered by the $25 annual fee paid by Oregon healthcare licensees. HB 2074 increases that fee to $35, to maintain sufficient capacity for program operations and database functions.

10. **Funding Aid and Assist Community Services** (HB 5024-OHA Budget)

OHA's budget includes $21.5 million for community restoration and clinical services, rental assistance and wraparound support, and OHA operations for supporting individuals who have been ordered by a court to receive services enabling them to "aid and assist" in their own criminal defense. The goal is to allow these patients to be served in their communities, when medically appropriate, in order to serve better them, avoid having them staying in local hospitals or jails, and free up space at the Oregon State Hospital for patients who need to be served there.

11. **Oregon State Hospital Funding** (HB 5024-OHA Budget)

OHA's budget includes $31 million general fund and 110 positions to open two 24-bed patient units at the Oregon State Hospital Junction City campus. These units will enable the Salem campus to make available more bed space to admit additional "aid and assist" patients. Separately, it establishes a $20 million appropriation to the Emergency Board to be available for supporting state hospital staffing levels contingent on OHA working with staff and other stakeholders to establish a sustainable plan. In addition, the capital budget includes funds for several deferred maintenance projects at the state hospital.

12. **Oregon State Hospital Technical Corrections** (SB 72)

SB 72 provides two statutory changes to ensure appropriate and efficient procedures at Oregon State Hospital (OSH). 1) A technical fix to ORS 127.720 to include ORS 426.701 to the list of types of commitments cited in the statute. ORS 426.701 took effect after ORS 127.720 was last amended and therefore was inadvertently excluded. 2) Allowing OSH to include outpatient services in the cost of care to a patient while at the state hospital. While OSH has a medical and dental clinic, patients at OSH come to the hospital with a variety of medical needs, some of which require sending patients to receive care at a facility outside OSH.

Reducing Barriers to Health and Addressing Health Inequities in our Communities

Health inequities are created by a variety of issues, most notably systemic injustices that lead to inequitable outcomes due to societal barriers related to race, ethnicity, tribal affiliation, gender, gender identity, sexual orientation and disabilities. The local circumstances in which each of us lives – including local public health services, environmental conditions, and availability of healthy housing, food, and recreation opportunities – can affect our health even more than access to healthcare services, but access to healthy communities is not equitable in Oregon. Critical needs include improved equity in communicable disease and emergency preparedness, more community voice in public health decision making, and climate mitigation strategies that center equity. Building healthier communities in large and small ways, together, especially in those places where people experience worse health outcomes and inequities, will help Oregonians be healthier and better advance health equity.

13. Modernize Public Health (HB 5024-OHA Budget)
For the past two biennia, the legislature has invested in modernizing state, local, and Tribal public health to more nimbly respond to emerging health issues. This biennium, the legislature added $45 million general fund to continue this work. Coupled with the $15 million general fund appropriated in the last biennium which is now part of the base budget, there will be a total of over $60 million available for public health modernization. The funding will largely support local public health authorities, community-based organizations, and Tribes to improve health outcomes through communicable disease control, emergency preparedness and response, health equity initiatives, and environmental health.

14. Build Health Equity Infrastructure (HB 5024-OHA Budget)
OHA's budget devotes $6.8 million to build and sustain health equity infrastructure within OHA and throughout Oregon. The addition of 17 new positions in the Division of Equity and Inclusion ensures that OHA has the programmatic, resource, operational, and staffing capacity that is critical to the goal of eliminating health inequities in Oregon by 2030. Among other things, this additional staff capacity buys increased expertise and capacity for community engagement and outreach. Investing in continuous and meaningful community engagement is essential to build trust and relationships with communities that experience the greatest health inequities due to structural and institutionalized oppression and racism. These include communities of color, people with disabilities, LGBTQ communities, immigrants, refugees, people with limited English proficiency, Tribes, and communities at the intersection of these identities. It is critical that OHA shift away from models where interactions with communities are transactional and largely occur only when the agency needs input or feedback for its own initiatives. The difference, from the perspective of those communities, lies in the opportunity to share in setting the agenda and making the decisions on policies and distribution of resources. Building on past work, this new investment will enable OHA to understand better the social determinants of health and health inequities, invest in continuous and meaningful community engagement, identify and prioritize community needs, and ultimately – with partners – develop innovative and sustainable solutions to achieve health equity. (Also, this funding is separate from a recent $33.9 million federal grant to advance health equity, which will establish 17 positions in the Public Health Division and provide resources to community-based organizations and Tribes. The budget bill formally incorporates that grant into OHA's budget.)

15. Expand Regional Health Equity Coalitions (SB 70)
SB 70 expands the statewide Regional Health Equity Coalition (RHEC) program, and also defines RHECs and the RHEC model in statute to ensure that they meet the same standards in serving their regions. The RHECs have the expertise based in lived experience to identify the most critical and regionally specific health equity issues, while crafting policy, system, and environmental solutions. Meaningfully impacting these issues and health inequities requires sustained, long-term efforts with dedicated funding. Specific benefits of sustained and expanded funding include: increased opportunities for coordinated care organizations (CCOs) to partner with RHECs and to offer technical assistance and training to build CCO capacity around health equity and the social determinants of health; providing coalitions the level of autonomy needed to improve health equity in meaningful and appropriate ways that ensures anti-racist priorities are not compromised; growing the necessary capacity of Oregon to address health equity in culturally specific and effective ways; and creating additional opportunities to sustainably address policy and system barriers.

16. Expand and Sustain Tribal Traditional Health Workers (HB 2088)
HB 2088 creates a sixth traditional health worker (THW) category specifically for and at the request of Tribes. Tribes are already providing critical health services to Tribal members, but many of these providers and practices do not fit within the five existing THW categories. Creating a sixth, separate THW category for Tribes would allow the Tribes and urban Indian health program to receive reimbursement using Tribal based practices and curricula developed by the Tribes themselves.

17. Recognize Racism as a Public Health Crisis (HR 6)
Some communities in Oregon, notably African American and Black, Native American and Alaska Native, Asian and Pacific Islander, and Latino/Latina/Latinx and Hispanic communities, experience consistently poorer health outcomes as measured in higher prevalence of chronic diseases, higher rates of infant and maternal mortality, shorter lifespans, and more. These health inequities fundamentally result from a history of systemic and contemporary racism in our society, and from current policies that perpetuate racist systems. HR 6 is the legislature's first explicit recognition of racism as a public health crisis.

18. Create Tobacco Retail Licensure (SB 587)
Even as tobacco use remains the top preventable cause of death and disability in Oregon, no state license has been required to sell tobacco products or inhalant delivery systems (IDS). In 2019, 16% of Oregon tobacco retailers illegally sold a tobacco product to a person under the age of 21. Without a state license, there is limited capacity to effectively enforce tobacco sales laws such as the minimum legal sales age. Through SB 587, tobacco retailer licensure will ensure retail store owners are following other state and local tobacco regulations and are held accountable for illegally selling tobacco to underage persons. Tobacco retail licensing fees allow for sustainable administration and enforcement of the program, including regular inspection. Enforcement action is taken on the retailers, not on the underage buyer. Other states with tobacco retail licenses show that it can reduce youth access to tobacco products.

19. Prohibit Remote Sales of Inhalant Delivery Systems (HB 2261)
Another important way to reduce the impact of tobacco products is to prohibit online and telephonic sale of inhalant delivery systems (IDS, also known as vaping products or e-cigarettes). From 2017-2019, use of inhalant delivery systems by Oregon 11th graders increased 80%. HB 2261 will reduce access and availability of IDS by removing online and retail sales mechanisms for purchasers in Oregon. It also means the rules for IDS sales will be the same as for cigarettes.

20. Improve Home Health Care Oversight (HB 2072)
Home health agencies provide skilled nursing services and other therapeutic services to patients in their homes. OHA is responsible for ensuring the quality of client care, conducting complaint investigations, and undertaking triennial surveys. Current fee levels do not support the cost of the regular surveys and complaint investigations. HB 2072 raises fees to support the necessary regulation of home health licensees and in doing so to protect Oregonians receiving their services.

21. Establish Healthy Homes Program (HB 2842)
HB 2842 establishes a Healthy Homes Program to provide financial assistance for repair, rehabilitation, and health and safety upgrades to residential housing occupied by members of low income and environmental justice communities. It provides a $10 million Healthy Homes Repair Fund and directs OHA to award grants to local governments, non-profit organizations, Oregon's nine federally-recognized Tribes, and nonprofit housing assistance programs, who in turn can provide financial assistance to low income households to repair and rehabilitate dwellings.

22. Sustain Radiation Protection Services (HB 2075)
Radiation Protection Services (RPS) is the state radiation control program protecting Oregonians from unnecessary or harmful exposure from radiation, and promoting beneficial uses of radiation. The program regulates over 4,200 registrants and licensees who provide services to patients and the public using 14,000 radiation devices and sources for medical, industrial, academic and research applications. Without additional funding to meet increasing demand, RPS will not be able to complete facility inspections of all registrants to ensure radiation devices/sources are being used safely and within manufacturer specifications. HB 2075 raises several fees paid by registrants and licensees, which will also better align Oregon's fee structure with the Washington and California tube-based fee models, and ensure that registrants are paying a fee based on the cost of inspection.

23. Remediate Lead-Based Paint Hazards (HB 2077)
Lead-based paint continues to be a critical environmental health risk that impacts brain development particularly for young children. Despite having delegated authority to enforce federal regulations on lead-based paint, OHA does not have the authority to require property owners, schools, or child care centers to properly assess and decontaminate a residence or facility. OHA can issue a citation if work was performed by uncertified firms or if lead-safe work practices were not followed, but it cannot mandate cleanup or issue stop-work orders in case of ongoing unsafe work. HB 2077 adds statutory authority for OHA to compel cleanup of a lead-contaminated site when OHA has determined that a property owner has violated lead-based paint requirements, and to issue a stop-work order if necessary.

24. Fund Universally Offered Home Visiting (HB 5024-OHA Budget)
OHA's budget includes $7.8 million (including $4.6 million general fund) to continue the phased roll-out of universally offered home visiting program approved in 2019.

25. Technical Fixes for Public Health (SB 64)
SB 64 contains several minor fixes to ease implementation of public health laws, including: bringing state law into alignment with federal regulations on lead-based paint remediation; clarifying the definitions of "health officer" and "local public health administrator"; and allowing School Health Services Planning Grant Sites to pursue either a School-Based Health Center (SBHC) or an alternative model (school nursing) as best fits their community needs.

Reducing Health Inequities in the Healthcare System and Realizing Better Care, Better Health, and Lower Costs

Oregon's overall health care system can be a powerful tool to reduce health inequities, improve care, and help Oregonians be healthier, all at a lower cost. This year, the legislature took several initiatives aimed at ensuring that the entire system – including public and private payors – works better for the people of Oregon.

26. Maintain Current OHA Services (HB 5024-OHA Budget)
HB 5024, OHA's budget bill fully funds OHA's current service levels. For the coming biennium, OHA generally will provide the same services it provided last biennium to Oregonians who need them. Most notably, the Oregon Health Plan (OHP) is fully funded, with no service cuts, even though membership has increased greatly due to COVID-19. (Under emergency public health

rules members have automatically been kept enrolled, whereas normally some would leave OHP every month.) The bulk of OHA's overall budget increase is tied to this caseload increase, as well as to inflation in OHP and other programs.

27. Cover All People (HB 3352)

HB 3352 expands the existing Cover All Kids program into the Cover All People program to provide affordable healthcare access to Oregonians who would be eligible for the Oregon Health Plan but for immigration status. The COVID-19 pandemic demonstrated again the importance of access to healthcare coverage, as people without access for testing and treatment suffered worse health outcomes. This was especially true among undocumented Oregonians, who are the largest remaining group in the state without access to coverage. The Cover All People concept was a priority recommendation of the Racial Justice Commission. The bill provides $100 million to fund the program for the next two years and directs OHA to develop an implementation plan that centers input from impacted communities. Legislators expressed an intent to review the program to determine appropriate funding levels for future biennia.

28. Collect Complete and Diverse Data (HB 3159)

Better, more complete data are critical to understanding health inequities and directing resources to eliminate them. Granularity in data collection assures that populations most affected by inequities are recognized, resourced, and supported in shaping policies and programs to address the inequities. Again, the COVID-19 pandemic highlighted the need for better data, especially relating to African American and Black, Native American and Alaska Native, Asian and Pacific Islander, and Latino/Latina/Latinx and Hispanic communities; whenever the data allowed for distinguishing smaller populations distinct from the overall population, it exposed the differential impacts on some populations and thus the need for greater and different responses required to serve those populations. HB 3159, known as the Data Justice Act, ensures that all surveys, data bases, and programs of OHA and the Oregon Department of Human Services collect complete data on race, ethnicity, language, and disability (REALD) and sexual orientation and gender identity (SOGI). It also requires health care providers, insurers, and CCOs to submit REALD and SOGI data to a registry developed by OHA. With the passage of this bill, Oregon leads the nation in data collection in areas of disability, sexual orientation, and gender identity, and goes above and beyond minimum federal standards for collecting race and ethnicity data.

29. Expand Telehealth Services (HB 2508)

During the pandemic, providing health services via telehealth became necessary. When done appropriately, telehealth can be highly effective and also cost-effective. HB 2508 expands coverage of, and reimbursement for, telehealth services in Oregon. Among other things, it requires the Oregon Health Plan and commercial insurance carriers to cover and reimburse telehealth services at the same rates as in-person services, requires health plans to ensure meaningful access to telehealth, and ensures that interpreters are reimbursed at the same rates as in-person.

30. Improve Language Access and Health Care Interpreters (HB 2359)

Quality language access services can improve health outcomes for patients who speak languages other than English or people who use sign language. HB 2359 requires OHA to train and certify or qualify health care interpreters and to maintain a central registry of certified or qualified health care interpreters. Health care providers are required to work with health care interpreters from that registry. This needed step further professionalizes Oregon's health care interpreter

workforce and ensures that a stable supply of quality trained interpreters is available across the state, especially in rural communities experiencing growth in populations who speak languages other than English.

31. Declare Access to Health Care a Right (SJR 12)
SJR 12 places a constitutional amendment on the 2022 general election ballot for consideration by voters. If approved, it would require the state to ensure that every resident of Oregon has access to cost-effective, clinically appropriate, and affordable health care as a fundamental right. This obligation must be balanced against the public interest in funding public schools and other essential public services.

32. Plan a Public Option (HB 2010)
HB 2010 directs OHA, in collaboration with the Department of Consumer and Business Services (DCBS), to develop a plan for implementing a public option health care plan to be offered to consumers on the individual market, and potentially in the small group market, for enrollment in 2024. OHA and DCBS are to report to the legislature on the implementation plan by January 1, 2022.

33. Provide Managed Care for Tribal Members (HB 5024-OHA Budget)
OHA's budget includes $15 million ($1.4 million state general fund, $13.5 million federal) to operate Indian Managed Care Entities. These entities will provide care coordination similar to how CCOs work for members of Oregon's nine federally recognized Tribes and Alaska Natives on the Oregon Health Plan, but specific to the needs of Tribal members.

34. Enforce Cost Growth of Health Care (HB 2081)
HB 2081 provides OHA with authority to implement mechanisms to hold insures and providers accountable for containing health care costs and meeting the annual 3.4% cost growth target established by SB 889 in 2019 and adopted by the Oregon Health Policy Board. SB 889 directed the OHA to work with stakeholders and consumers to set a Sustainable Health Care Cost Growth Target that would apply to insurance companies, hospitals and healthcare providers, so that healthcare costs do not outpace wages or the state's economy. HB 2081 adds Performance Improvement Plans as the first accountability mechanism for payers and provider organizations that exceed the cost growth target, and provides for financial penalties.

35. Expand Dental Therapy Licensure (HB 2528)
HB 2528 expands dental therapist licensing, under the supervision of a dentist, to provide for services to underserved populations and patients in dental care health professional shortage areas. This expansion of services ensures broader and more timely access in communities where dental care services are lacking.

36. Leverage the Purchasing Power of the Marketplace (SB 65)
Currently, the Department of Consumer and Business Services (DCBS) administers the Health Insurance Exchange (the Marketplace) for purchasing health plan coverage under the Affordable Care Act (ACA). SB 65 moves responsibility for running the Marketplace to OHA. This will allow OHA to coordinate improving quality and reducing cost in health care coverage across Medicaid, public employee plans, and ACA plans sold through the Marketplace. It will significantly enhance OHA's ability to align new payment methodologies and expand on models for better coordinating patient care and health equity.

37. Review Health Care Mergers and Acquisitions for Access and Equity (HB 2362)
In order to ensure Oregon's private market health care system transformation aligns with the state's core priority health care principles of better care, better health, and lower costs – and the health equity strategic goal – HB 2362 provides enhanced regulatory authority over certain proposed mergers and acquisitions involving major health systems in Oregon. The process will guarantee transparency and provide an opportunity for public input on whether a proposed merger and acquisition is warranted, to protect against loss of access to health care services and increased costs.

38. Support Ground Emergency Medical Transport Services (HB 2910)
HB 2910 allows OHA to seek approval from the federal Centers for Medicare and Medicaid Services (CMS) for a supplemental payment program for privately operated ambulance service agencies. If approved, OHA will annually assess a quality assurance fee on each emergency medical transport provided by a private ambulance service. Ambulance service agencies will be reimbursed for an emergency medical service transport by a formula prescribed in the bill. A portion of the reimbursement funds must be used to increase wages and benefits of employees. Additionally, the bill raises ambulance service and ambulance vehicle licensing fees to support regulatory oversight of the agencies and vehicles.

39. Technical Fixes for Health Policy and Analytics (HB 2078)
HB 2078 makes minor technical corrections to implement existing statutes as intended. The changes include: repealing the Common Credentialing program; eliminating the requirement for the Pain Management Commission to perform curriculum reviews; revising requirements for licensed professionals to periodically complete a pain management education program; and amending PEBB's statute so it aligns with the Affordable Care Act regarding the coverage of temporary employees.

The profound challenges of the past year affected everyone in Oregon, with the greatest health impacts typically on individuals and communities who already experience health inequities. These events contributed to a desire for transformative changes in how OHA and our health systems help Oregonians live healthier lives. The health equity investments and initiatives passed by the legislature this year provide OHA and its partners new opportunities to center health equity and work to eliminate health inequities.

# # #

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help or have questions, please contact Matthew Green at 503-983-8257, 711 TTY, matthew.green@dhsoha.state.or.us.

minutes

PUBLIC HEALTH ADVISORY BOARD
Incentives and Funding Subcommittee
Meeting minutes, draft

July 13, 2021
4:00-5:00 pm

Subcommittee Members present: Carrie Brogoitti, Bob Dannenhoffer, Veronica Irvin, Rebecca Tiel

Subcommittee Members absent: none

OHA staff: Sara Beaudrault, Cara Biddlecom

Welcome and introductions

2021-23 public health modernization Legislative investment
Cara provided an update and overview.

- The legislature allocated an additional $45 million for the 2021-23 biennium. This is added on to the OHA base budget for public health modernization, for a total of just over $60 million.
- A year ago PHAB talked about funding priorities and agreed to continue the investment in health equity and community partnership development, emergency preparedness and communicable disease.
- This is the first biennium we will be bringing focus and resources to environmental health, including climate resilience and nonregulatory programs toward environmental justice. Thinking about recent extreme heat events and the threat of wildfires, all are closely linked at the nexus of communicable disease, environmental health and emergency preparedness, all centered on equity.
- The majority of funds go to LPHAs, federally-recognized Tribes and the Urban Indian Health Program, and community-based organizations.
- Funds that remain with OHA will build capacity for data collection and surveys; workforce development; communicable disease testing and laboratory services; IT and data infrastructure; staff needed to manage the investment and provide subject matter expertise.

Veronica asked about the funding for community-based organizations.

Cara responded that OHA is working with an advisory committee of CBOs to map out how to build on the strengths for community-based and equity-focused work through this funding. This group is exploring the work that CBOS are equipped to do and want to do. Examples are health communications and engagement; culturally responsive direct connections into communities; participating with LPHAs to develop health equity plans; and potentially policy and system

changes. OHA will bring together CBO and LPHA leaders for a conversation about how we map the CBO and LPHA pieces together in a way that is cohesive and builds on the strengths of partners.

Veronica confirmed that these funds will go directly to CBOs.

Cara confirmed that this is correct.

Bob noted that the CBO funding is a relatively new program that has had ups and downs. This is an area where PHAB will want to be involved.

Rebecca asked whether the phased approach to implementing foundational programs is still being used.

Sara replied that this framework is still being used. When PHAB did their funding prioritization work a year ago, PHAB stuck with this approach. We are still in phase 1. In terms of implementation, OHA and LPHA administrators are focused on building the infrastructure needed to do programmatic work, based on foundational capabilities.

Rebecca commented that she thinks regional staffing should be focused on foundational capabilities rather than providing programmatic subject matter expertise. She likes the approach of regional staffing but doesn't want it pigeon-holed into programmatic work only.

2021-23 public health modernization funding formula

- Make recommendations for matching and incentive fund components of funding formula
- Make recommendations for regional funding to local public health authorities

Sara reviewed the funding formula and how it is used to allocate funds to local public health authorities. It is not used for regional funding, or funding to other groups like Tribes or CBOs.

<u>Matching and incentive funds</u>
Sara said that in 2019, all funds went out through the base component, with no funds awarded for matching funds. Matching funds are intended to be awarded to LPHAs for investing in public health services or activities and are intended to encourage sustained and increased local investments. Incentives to be paid based o achieving public health accountability metrics, ensure improvements and equitable

Veronica reminded the group that it had talked last year about adding an indicator for migrant and seasonal farmworkers. Was there any discussion about adding this as an indicator now?

Bob said that no movement has been made. Seasonal workers had a real impact on many areas. When we think about communicable disease and environmental health threats, seasonal workers have an outsized impact. He recommends not making changes to indicators at this time.

Bob also noted that matching funds will be hard to do in the next two years. All the funding that has come in to LPHAs through the county will be very hard to parse out. Matching funds have never made up a big part of the funding formula, and maybe PHAB should delay this piece. Similarly, LPHAs have been focused on other areas during the pandemic and this may not be the right time to award funding based on the accountability metrics.

Sara responded to Veronica's question about adding an indicator for migrant and seasonal farmworkers. This can be revisited when the subcommittee begins working on this funding formula for the 2023-25 biennium and will look at all indicators together to see what changes are needed.

Sara said CLHO had an opportunity to talk about matching and inventive funds. CLHO agreed with OHA's proposal to collect data in upcoming biennium but not make awards until 2023-25. Does the subcommittee recommend waiting or do they want OHA to find a way to award in this biennium?

Bob suggested waiting.

Rebecca said any pause or strategic opportunities to consider impacts is appropriate right now. She also wants to keep the eye on transformation. PHAB needs to recognize where we are in terms of recovery but doesn't want to lose this for the future.

Bob said that waiting will delay the implementation of funds, but not the efforts toward modernization. What we're learning is that modernization was the right path to start with.

Veronica asked if there are safeguards that can be put in place if we don't have the matching funds in the next biennium to avoid county reductions in public health funding.

Bob agrees with the question but does not know how to do this. He reiterated that it will be very hard to separate out all of the current funding.

Carrie feels strongly that the purpose of matching funds is to continue to have increased investments. Holding off seems reasonable, given CLHO's support. Each county is different in terms of local General Fund investment. Reductions have a different impact based on how much a county is getting. Could the contract include ac clause that a county must maintain funding levels in order to accept modernization funding?

Rebecca asked about including a requirement to maintain current service level minimums or something similar. This should be studied or reported on… what happens when there is a big influx of funds and then they go away? This may be a bigger discussion for PHAB or others.

Veronica asked whether a clause can be added to contracts, like Carrie suggested.

Rebecca asked whether there could be a requirement to demonstrate contribution of local funds in order to access regional modernization funding.

Carrie asked whether conversations have already happened about how funds will be distributed through the funding formula. Disparities occur when some LPHAs don't have enough base funding. Have decisions been made about base funding to LPHAs?

Sara said that floor payments increase proportionally as funding increases.

Subcommittee recommendation:

- Don't award matching or incentives payments in 2021-23, but collect information and plan for awarding funds in 2023-25.

- Consider opportunities to understand the likely impacts on LPHA funding as COVID funding ends. This could include existing studies or a survey of LPHAs to learn about impacts.

Regional funding
Sara shared that the CLHO Systems and Innovation committee has been thinking about different ways to expand the regional model.

A survey of LPHAs was conducted in early 2020, right at the beginning of COVID. The feedback showed that health administrators generally were in favor of retaining some sort of regional funding at same or increased level. There were differences among extra small and extra large counties.

In the past year, most regional partnerships have continued to function to some degree, although the focus has been on local COVID responses.

CLHO Systems and Innovation noted issues with current regional funding. The model for regional partnerships has been inflexible and has not allowed LPHAs to use funds to meet needs. Often one county has benefitted more from regional positions than others in the partnership. And CLHO Systems and Innovation is interested in exploring whether funding could be available for regional work as it is needed, rather than only at the beginning of the funding period.

Rebecca said that from hospital perspective, a regional approach doesn't always work. If there is a reason to work regionally, it often works well for projects that are tied to a natural system or partnership. She asked how we can break down the barriers and give people the flexibility tat is needed.

Bob agrees with flexibility and finding out what really does work. He could imagine that regional planning or hub and spoke models might work in some areas. He would suggest holding the funding steady at 2019-21 levels. It's not shocking that smaller counties have benefitted the most.

Carrie said that regional models haven't worked well for all smaller counties. She said that during COVID, it has worked well for another county to provide case investigation and contact tracing for her county. She also gave an example of regional health equity assessments, which was beneficial but also challenging because the LPHA didn't have capacity to participate. She has been thinking about environmental health wok. If they don't get enough money to do that work, they won't be able to do it unless they do it through a regional partnership. For her, flexibility and being really thoughtful about where the resources have meaning is what she would like to see.

Sara noted that it important to be building capacity everywhere and not create a system where some counties have the resources to do the work and others don't.

Carrie said that there is a place for regional work and there needs to be acknowledgement that it doesn't always work and shouldn't be forced. There needs to be capacity within a county in order to participate in regional work.

Bob noted that we are trying something entirely new and if all new approaches worked well, we probably weren't being bold enough. Work on climate change will require hiring people well-skilled in this, probably not people currently on staff. A county can't use all of their funding on that one position. Flexibility and ability to experiment is needed.

Veronica appreciates the flexibility built into the three options.

Recommendations:

- Ensure flexibility and additional options for using regional funding
- Keep regional funding at current levels. As each of the counties have more money, the need for regional money may decrease.

Subcommittee business

No additional subcommittee meetings are scheduled at this time.

Bob agreed to provide the subcommittee update at July 15 PHAB meeting

Public comment

Morgan Cowling with the Coalition of Local Health Officials appreciated the conversation and the issues the committee addressed. She noted the funds coming into local public health system, including local and federal funding. There may continue to be shifting of funds. She agrees with trying to collect data in this biennium; this seems like the right thing to do right now.

Morgan continues to think about how to raise capacity in all parts of the state everywhere. She continues to think we need to get additional staff capacity in every health department, no matter what so they have the capacity to engage in regional work. She is concerned that small and extra small counties will not even receive enough funding for a part time staff person. This is the single largest investment the Legislature has made in public health and to not be able to say that extra small counties can hire a half time position to do the work is troubling. When the funding formula was created, we never thought about using it for a $50 million investment. It would be good for PHAB to continue to think about this to ensure capacity everywhere that is dedicated to this work.

Adjourn

Introducing Health Resources in Action

Presentation to the Public Health Advisory Board

July 15, 2021

Health Resources in Action
Advancing Public Health and Medical Research

About Health Resources in Action

Public health institute based in **Boston, MA**

Our vision: A world where all people attain and experience optimal health and well-being.

Meet Our Team

Brittany Chen
Managing Director, Health Equity

Moacir Barbosa
Senior Director, Community Engagement

HRiA Health Equity Framework

Health Resources in Action
Advancing Public Health and Medical Research

Framework principles

How do efforts **challenge commonly held assumptions and narratives?**

How are we **creating and sustaining authentic and diverse engagement?**

How are we **strengthening capacity to correct power imbalances?**

Our Approach to Advancing Health Equity

Assess unique capacity building needs

Lead with race

Integrate head and heart

Create brave spaces

Health Equity and Leadership (HEAL): *Advancing Health Equity in Oregon*

Health Equity and Leadership: Vision

To equip Oregon's PHD workforce to eliminate health inequities by 2030 – through their individual and collective work in communities, and through their work culture and relationships

Health Equity and Leadership Journey Goals

- **Establish a baseline** for shared definitions and skills for understanding, defining, and operationalizing health equity, racial equity and related concepts

- **Create brave spaces** to challenge oneself and one another via deep learning, reflection, and actions via trauma-informed practices – connecting head, heart, and guts

- **Examine White Supremacy Culture** in organizational systems, policies, and practices and explore concrete actions to dismantle it within PHD

- Explore how to **practically advance equity** through work and approaches of PHD's sections, aligned with the strategic directions of PHD and OHA

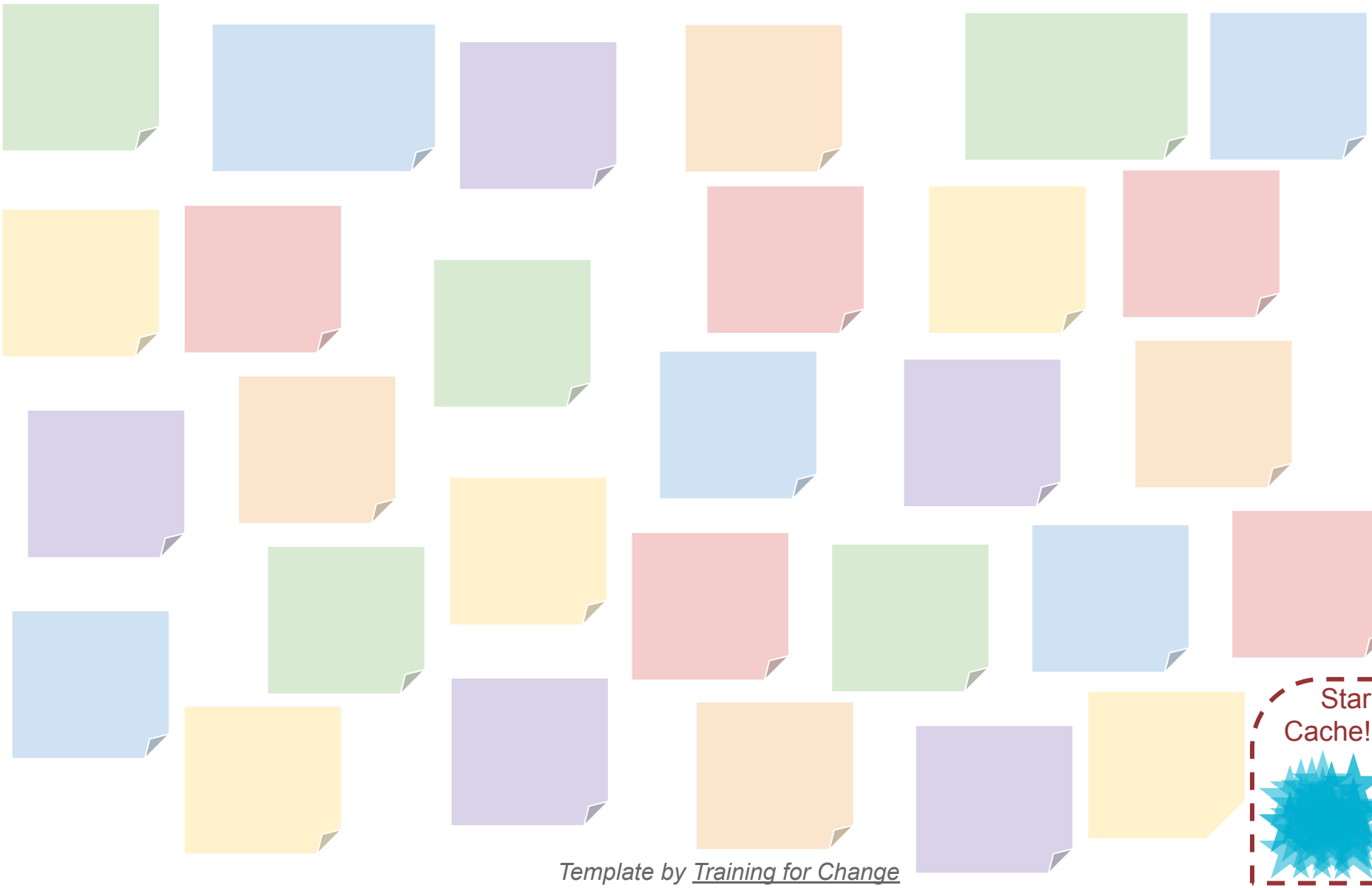
Other examples

Equity-focused capacity building

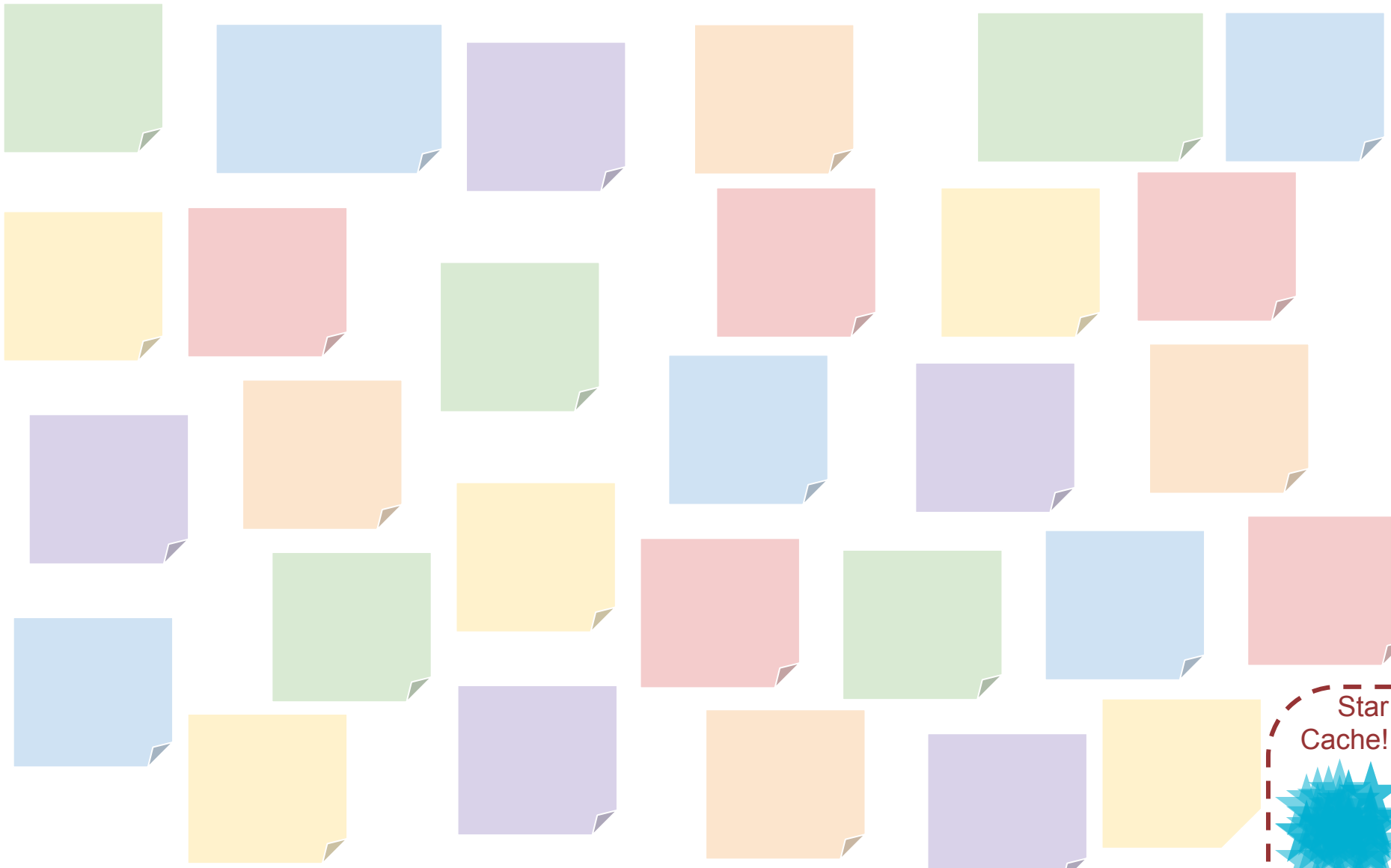
Mass in Motion ©

Thank you! + Q&A

What capacity building topics or concepts would be of greatest interest?



What hopes do you have for capacity building support?



What other questions or ideas do you have?